

This form is to be used for reporting all incidents connected with work, which involves an injury (including an act of physical violence), or a near miss. The person involved in the accident/incident must complete all sections of this form. If they are unable to do so then the relevant line manager/supervisor or Head Teacher should complete it. Send this original form to the **Health & Safety Team at Wallasey Town Hall, Brighton Street, Wallasey CH44 8ED**. Contact No 0151 606 2364 or email to healthsafetyandresilience@wirral.gov.uk.

Part 1

About any injured person

If reporting a near miss go to Part 3. If more than one person was injured in the same incident, please complete a separate accident report for each person.

1 What is their full name?

2 What is their home address?

Postcode

3 What is their home telephone number?

4 What is their DOB?

5 Are they Male Female

6 Employee Number

7 Post Number

8 What is their job title?

9 Is the injured person: (X the box that applies)

One of your employees?

On work experience / On a training scheme?

Volunteer?

Employed by someone else?

Self-employed and at work?

A member of the public?

A visitor?

A service user / A pupil?

What is the unique pupil number?

10 Is/was the person absent from work as a result of the injury?

Yes No

If yes has this been recorded on the SD1? Yes No

11 On the date of the accident, between what hours:

(a) Did the injured person expect to work?
 from to

(b) Did the injured person actually work?
 from to

About any injury

1 What was the injury? (eg fracture, laceration)

2 What part of the body was injured?

3 Was the injury (X in the box that applies):

A fatality?

A specified injury? (see accident policy)

an injury to an employee or self-employed person which prevented them from doing their normal work for

- > more than 3 days (including non-work days)?
- > more than 7 days (including non-work days)?

an injury to a member of the public which meant they had to be taken from the scene of the accident to a hospital for treatment?

4 Did the injured person (X all the boxes that apply):

Become unconscious?

Need resuscitation?

Remain in hospital for more than 24 hours?

None of the above?

Part 3

About the incident

1 On what date did the incident happen?

2 At what time did the incident happen? (Please use 24 hr clock, eg 0600)

3 Where did the incident happen? State the address and postcode of the premises

Postcode

4 Where on the premises did the incident happen?

5 On what date were details of the incident recorded in: the Pupil Record (M36)

6 Give name and address of all witnesses (if no witnesses please state NONE)

Witness Accounts attached Yes No

Part 2

Part 4

Describing what happened

Give as much detail as you can. For instance:

- the name of any substance involved;
- the name and type of any machine involved;
- the events that led to the incident;
- the part played by any people;
- please provide photographs or sketches
- please state if CCTV footage is available

If it was a personal injury, give details of what the person was doing. Describe any action that has since been taken to prevent a similar incident. Use a separate piece of paper if you need to.

Part 5

About the kind of accident

Please X the one box that best described what happened.

- | | | |
|----|--|--------------------------|
| 1 | Contact with machinery | <input type="checkbox"/> |
| 2 | Struck by object | <input type="checkbox"/> |
| 3 | Struck by a moving vehicle | <input type="checkbox"/> |
| 4 | Struck against | <input type="checkbox"/> |
| 5 | Lifting and handling injuries | <input type="checkbox"/> |
| 6 | Slipped, tripped or fell on the same level | <input type="checkbox"/> |
| 7 | Fell from height | <input type="checkbox"/> |
| | How high was the fall? <input type="text"/> Metres | |
| 8 | Trapped by something collapsing | <input type="checkbox"/> |
| 9 | Drowned or asphyxiated | <input type="checkbox"/> |
| 10 | Exposed to a harmful substance | <input type="checkbox"/> |
| 11 | Exposed to fire or smoke | <input type="checkbox"/> |
| 12 | Exposed to an explosion | <input type="checkbox"/> |
| 13 | Contact with electricity | <input type="checkbox"/> |
| 14 | Injured by an animal | <input type="checkbox"/> |
| 15 | Physically assaulted | <input type="checkbox"/> |
| 16 | Another kind of accident (as described in Part 4) | <input type="checkbox"/> |

Employee Signature

Date

Part 6: Your Section head/Line Manager /Supervisor or Head teacher must complete this section.

About you

1 What is your full name:

2 What is your Post Number and Job Title?

3 What is your work telephone number?

4 What is your work address?

Postcode

5 Your signature

Date

Part 7

Management action taken to prevent recurrence

Has the risk assessment been reviewed? Yes No

Part 8

Safety Officer's comments.

RIDDOR Reporting Date:

5 Signature

Date

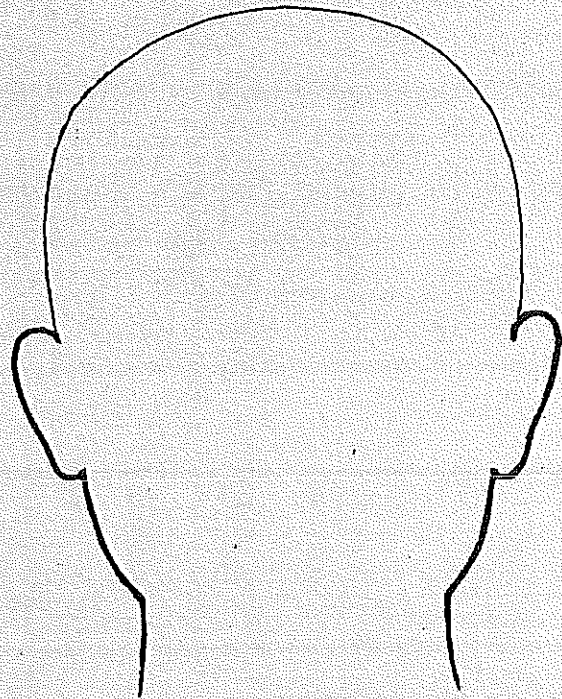
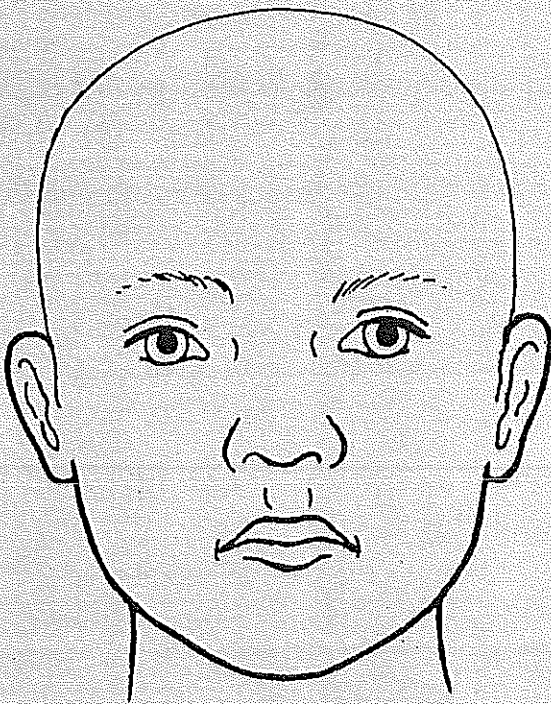
Any Forms Submitted Incomplete Will be Returned

Child's Name _____

Class _____



Head Injury Leaflet



SCHOOL STAFF TO COMPLETE

Date Time

Location of injury to be marked on diagram

Fell from greater than their own height	<input type="checkbox"/>	Vomited x1	<input type="checkbox"/>
Collided with	<input type="checkbox"/>	Vomited x2	<input type="checkbox"/>
Landed on a hard surface	<input type="checkbox"/>	Vomited x3	<input type="checkbox"/>
Landed on a soft surface	<input type="checkbox"/>	Vomited >3	<input type="checkbox"/>
Lost consciousness when they fell	<input type="checkbox"/>	Can't remember events before the accident	<input type="checkbox"/>
Had a fit/seizure	<input type="checkbox"/>	Can't remember events since the accident	<input type="checkbox"/>
Cried immediately	<input type="checkbox"/>		

ADVICE FOR PARENTS/CARERS

Your child has bumped their head today.

- Allow them to rest, with ideally no screentime (TV or tablet etc) for about 48 hours.
- Watch them carefully for the first 48 hours after the injury.
- You can give Paracetamol **or** Ibuprofen for a mild headache, if you have to give both we would advise you to see a doctor for assessment.
- Allow them to go to sleep as usual and check on them from time to time while you are awake. If they don't stir when you touch them, wake them up fully.

Bring them to the nearest Childrens' Emergency Department if any of the following happen:

- Their headache gets worse despite Paracetamol or Ibuprofen.
- They continue to vomit.
- Poor coordination/clumsiness/unsteady walking.
- Weakness in arms or legs or one side of their face.
- They become unconscious/don't respond to you.
- Excessive drowsiness (difficult to wake when you try to wake them).
- Bump to the head getting larger or squashier.
- Problem with eyesight or hearing.
- Slurred or unclear speech.
- Fluid/blood coming from ears/nose.
- Has a fit or collapses.
- Unusual or confused behaviour.
- If it looks like the child has a dent or large cut on their head.
- If the child is complaining of neck pain.
- Your child has a known bleeding disorder.

These symptoms are not always serious, but it is best to get a doctor to check them out. If you are worried at all, don't hesitate to see a doctor - either your GP or a doctor in the Emergency Department will be very happy to see and assess your child.

Please bring this leaflet with you if you seek medical advice.

Appendix C

BLACK HORSE HILL INFANT SCHOOL

CHILD'S NAME

CLASS

DATE

Your child has been treated today for an injury to

The injury was treated with

If you are at all concerned about your child please consult a doctor.

IN CASE OF HEAD INJURY – if your child becomes sick, dizzy, drowsy or complains of a headache please seek medical attention.

BLACK HORSE HILL INFANT SCHOOL

CHILD'S NAME

CLASS

DATE

Your child has been treated today for an injury to.....

The injury was treated with.....

If you are at all concerned about your child please consult a doctor.

IN CASE OF HEAD INJURY – if your child becomes sick, dizzy, drowsy or complains of a headache please seek medical attention.

Appendix D



FORM 3B

Parental agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

Name of school	Black Horse Hill Infant School
Date	
Child's name	
Class	
Name and strength of medicine	
Expiry date	
How much to give (i.e. dose to be given)	
Any other instructions	
Number of tablets/quantity to be given to school	

Note: Medicines must be in the original container as dispensed by the pharmacy

Daytime phone no. of parent/carer	
Name and phone no. of GP	
Agreed review date to be initiated by	

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that a non-medical professional will administer my child's medication, as defined by the prescribing professional only

Parent/carer's signature _____

Print name _____

Date _____

If more than one medicine is to be given a separate form should be completed for each one.

Appendix E

Black Horse Hill Infant School

Child's name.....

Class.....

Date.....

Your child has had an accident today at school and his/her clothing has been changed.

We would appreciate it if you could wash and return
the clothing to school as soon as possible.

Many thanks

BLACK HORSE HILL INFANT SCHOOL - MONTHLY ACCIDENT ANALYSIS SUMMARY

Date:

CAUSES OF ACCIDENTS										
Year Group	Slips, trips and falls	Falls from height	Collision with structure/person	Struck by flying object	Struck by another person	Struck by falling object	Moving and handling			
Y2										
Y1										
F2										
F1										
Totals										
LOCATION OF ACCIDENTS										
Year Group	Playground	Classroom	Corridor	Toilets	Offices	Library	Other			
Y2										
Y1										
F2										
F1										
Totals										
TYPES OF INJURIES										
Year Group	Graze	Bruise	Cut/laceration	Strain/sprain	Fracture	Loss of teeth	Head injury	Foreign body ear/eye/nose	Other	
Y2										
Y1										
F2										
F1										
Totals										

Appendix F